COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Platinum Coinsurance Plan		Platinum Copay Plan		
3/15/2013						
Actuarial Value - F	inal AV Calculator		88.19	6	88.0%	
Overall deductible			\$0		\$0	
	for specific services		Ψ		Ţ.	
	Medical		\$0		\$0	
	Brand Drugs		\$0		\$0	
	Dental		See attach	nment	See attach	nment
Out-of-pocket lim	it on expenses		\$4,00	0	\$4,00	0
Common Medical Event	Service Typ	е	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an inj footnote)	ury or illness (see	\$20		\$20	
office or clinic	Specialist visit		\$40		\$40	
	Other practitioner office visit		\$20		\$20	
	Preventive care/ screening/ imr	nunization	No cost share		No cost share	
	Laboratory Tests		\$20		\$20	
Tests	X-rays and Diagnostic Imaging		\$40		\$40	
	Imaging (CT/PET scans, MRIs)	1	10%		\$150	
Drugs to treat	Generic drugs		\$5		\$5	
illness or	Preferred brand drugs		\$15		\$15	
condition	Non-preferred brand drugs		\$25		\$25	
	Specialty drugs		10%		10%	
Outpatient	Facility fee (e.g., ASC)		10%		\$250	
surgery	Physician/surgeon fees		10%		#450	
	Emergency room services (waived if admitted)		\$150 \$150		\$150 \$150	
Need immediate attention	Emergency medical transportation Urgent care		\$150 \$40		\$40	
Heapital stay	Facility fee (e.g., hospital room)	10%		\$250 per day up	
Hospital stay	Physician/surgeon fee		10%		to 5 days	
	Mental/Behavioral health outpa	tient services	\$20		\$20	
Mental health, behavioral health,	Mental/Behavioral health inpati	ent services	10%		\$250 per day up to 5 days	
or substance	Substance use disorder outpat	ent services	\$20		\$20	
abuse needs	Substance use disorder inpatie	nt services	10%		\$250 per day up to 5 days	
	Prenatal care and preconception		No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up	
	services	Professional	10%		to 5 days	
	Home health care Rehabilitation services		10%		\$20	
Help recovering	Habilitation services		\$20 \$20		\$20 \$20	
or other special					\$150 per day up	
health needs	Skilled nursing care		10%		to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
Child needs	Glasses		1 pair per year		1 pair per year	
dental or eye care	Dental Check-up - Preventive a Dental Basic Services		See Pediatric Der Plan Design, No		See Pediatric Der Plan Design, No	
	Dental Restorative and Orthodo	onua Services			a. 200.g., 110.0 0 20.0W	

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS			Gold Coinsurance Plan		Gold Copay Plan	
3/15/2013						
Actuarial Value - Final AV Calculator			78.2%		78.0%	
Overall deductible			\$0		\$0	
	for specific services		Ψū		40	
	Medical		\$0		\$0	
	Brand Drugs		\$0		\$0	
	Dental		See attack	nment	See attach	nment
Out-of-pocket lim	it on expenses		\$6,40	0	\$6,40	0
Common Medical Event	Service Type	e	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an injufootnote)	ury or illness (see	\$30		\$30	
office or clinic	Specialist visit		\$50		\$50	
	Other practitioner office visit		\$30		\$30	
	Preventive care/ screening/ imm	nunization	No cost share		No cost share	
	Laboratory Tests		\$30		\$30	
Tests	X-rays and Diagnostic Imaging		\$50		\$50	
	Imaging (CT/PET scans, MRIs)		20%		\$250	
Drugs to treat	Generic drugs		\$20		\$20	
illness or	Preferred brand drugs		\$50		\$50	
condition	Non-preferred brand drugs		\$70		\$70	
Outractions	Specialty drugs		20%		20%	
Outpatient	Facility fee (e.g., ASC) Physician/surgeon fees		20% 20%		\$600	
surgery	Emergency room services (waiv	(ed if admitted)	\$250		\$250	
	Emergency medical transportat		\$250		\$250	
Need immediate attention	Urgent care		\$60		\$60	
Heavital stay	Facility fee (e.g., hospital room)		20%		\$600 per day up	
Hospital stay	Physician/surgeon fee		20%		to 5 days	
	Mental/Behavioral health outpar	tient services	\$30		\$30	
Mental health, behavioral health,	Mental/Behavioral health inpation		20%		\$600 per day up to 5 days	
or substance	Substance use disorder outpati	ent services	\$30		\$30	
abuse needs	Substance use disorder inpatie		20%		\$600 per day up to 5 days	
_	Prenatal care and preconceptio		No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20%		\$600 per day up	
	services	Professional	20%		to 5 days	
	Home health care Rehabilitation services		20% \$30		\$30 \$30	
Help recovering	Habilitation services		\$30		\$30	
or other special	r other special				\$300 per day up	
Skilled nursing care		20%		to 5 days		
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
Child needs	Glasses		1 pair per year		1 pair per year	
dental or eye care	Dental check-up - Preventive ar	nd Diagnostic	See Pediatric De	ntal Standard	See Pediatric Der	ntal Standard
asinar or oyo care	Dental Basic Services	0	Plan Design, No		Plan Design, No	
	Dental Restorative and Orthodo	ontia Services	rain boorgii, Note o below		. Idil Doorgii, Note o Delow	

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:
- http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf

Covered California Standard Benefit Plan Designs - FINAL

	enefits and Coverage		Individ	ual	Individ	ual	
•	•				- Au		
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS			Silver Coinsurance Plan		Silver Copay Plan		
3/15/2013							
Actuarial Value - F	inal AV Calculator		68.7%	%	68.3%	6	
Overall deductible			N/A		N/A		
Other deductibles	for specific services						
	Medical		\$2,00		\$2,00		
	Brand Drugs Dental		\$250 See attacl		\$250 See attach		
Out-of-pocket lim			\$6,40		\$6,40		
·	·						
Common Medical Event	Comice Time		Member Cost	Deductible	Member Cost	Deductible	
Event	Service Type		Share	Applies	Share	Applies	
Visit to a health care provider's	Primary care visit to treat an injufootnote)	ıry or illness (see	\$45		\$45		
office or clinic	Specialist visit		\$65		\$65		
	Other practitioner office visit		\$45		\$45		
	Preventive care/ screening/ imm	unization	No cost share		No cost share		
Tests	Laboratory Tests X-rays and Diagnostic Imaging		\$45 \$65		\$45 \$65		
10313	Imaging (CT/PET scans, MRIs)		20%	X	\$250		
Drugo to troot	Generic drugs		\$25		\$25		
Drugs to treat illness or	Preferred brand drugs		\$50	Х	\$50	Х	
condition	Non-preferred brand drugs		\$70	X	\$70	X	
	Specialty drugs		20%	X	20%	Х	
Outpatient	Facility fee (e.g., ASC)		20%	Х	20%	Х	
surgery	Physician/surgeon fees Emergency room services (waiy	ed if admitted)	20% \$250	X	20% \$250	X	
Emergency room services (waived if admitted) Emergency medical transportation		· · · · · · · · · · · · · · · · · · ·	\$250	X	\$250	X	
Need immediate attention	Urgent care		\$90		\$90		
Hospital stay	Facility fee (e.g., hospital room)		20%	X	20%	Х	
riospitai stay	Physician/surgeon fee		20%			^	
Montal books	Mental/Behavioral health outpat	ient services	\$45		\$45		
Mental health, behavioral health,	Mental/Behavioral health inpatie		20%	Х	20%	Х	
or substance	Substance use disorder outpatie	ent services	\$45		\$45		
abuse needs	Substance use disorder inpatier	nt services	20%	Х	20%	Х	
	Prenatal care and preconception		No cost share		No cost share		
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х	20%	Х	
	Home health care	Professional	20%		\$45		
	Rehabilitation services		\$45		\$45		
Help recovering Habilitation services			\$45		\$45		
or other special health needs	Skilled nursing care		20%	Х	20%	Х	
	Durable medical equipment		20%		20%		
	Hospice service		No cost share		No cost share		
	Eye exam (deductible waived)		0%		0%		
Child needs	Glasses	d Diographia	1 pair per year		1 pair per year		
dental or eye care	Dental Check-up - Preventive and Dental Basic Services		See Pediatric Dental Standard Plan Design, Note 6 Below		See Pediatric Der Plan Design, No		
	Dental Restorative and Orthodo	ntia Services	5 ,		J ,		

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:
- http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf

Covered California Standard Benefit Plan Designs - FINAL

Summary of Be	ummary of Benefits and Coverage		SHOP		SHOP	
	S AMOUNTS DESCRIBE THE OUT OF POCKET COSTS		Silver Coinsurance Plan		r Plan	
3/15/2013						
Actuarial Value - F	inal AV Calculator	69.8%	%	69.3%	6	
Overall deductible		N/A		N/A		
	for specific services	IV/A		I W/A		
	Medical	\$1,50	0	\$1,50	0	
	Brand Drugs	\$500		\$500		
	Dental	See attack		See attack		
Out-of-pocket lim	it on expenses	\$6,40	0	\$6,40	0	
.						
Common Medical Event		Member Cost Share	Deductible Applies	Member Cost Share	Deductible	
Event	Service Type	Silare	Applies	Share	Applies	
Visit to a health care provider's	Primary care visit to treat an injury or illness (see footnote)	\$45		\$45		
office or clinic	Specialist visit	\$65		\$65		
	Other practitioner office visit	\$45		\$45		
	Preventive care/ screening/ immunization	No cost share		No cost share		
	Laboratory Tests	\$45		\$45		
Tests	X-rays and Diagnostic Imaging	\$65	24	\$65		
	Imaging (CT/PET scans, MRIs)	20%	Х	\$250		
Drugs to treat	Generic drugs Preferred brand drugs	\$25 \$50	V	\$25 \$50	V	
illness or	Non-preferred brand drugs	\$70	X	\$70	X	
condition	Specialty drugs	20%	X	20%	X	
Outpatient	Facility fee (e.g., ASC)	20%	X	20%	X	
surgery	Physician/surgeon fees	20%		20%		
	Emergency room services (waived if admitted)	\$250	X	\$250	X	
	Emergency medical transportation	\$250	Х	\$250	Х	
Need immediate attention	Urgent care	\$90		\$90		
	Facility fee (e.g., hospital room)	20%	Х	200/	V	
Hospital stay	Physician/surgeon fee	20%		20%	Х	
	Mental/Behavioral health outpatient services	\$45		\$45		
Mental health, behavioral health,	Mental/Behavioral health inpatient services	20%	Х	20%	Х	
or substance	Substance use disorder outpatient services	\$45		\$45		
abuse needs	Substance use disorder inpatient services	20%	Х	20%	X	
	Prenatal care and preconception visits	No cost share		No cost share		
Pregnancy	Delivery and all inpatient Hospital	20%	Х	20%	Х	
	services Professional Home health care	20%		\$45		
	Rehabilitation services	20% \$45		\$45 \$45		
Help recovering	Habilitation services	\$45		\$45		
or other special health needs	Skilled nursing care	20%	X	20%	Х	
	Durable medical equipment	20%		20%		
	Hospice service	No cost share		No cost share		
	Eye exam (deductible waived)	0%		0%		
Child needs	Glasses	1 pair per year		1 pair per year		
dental or eye care	Dental check-up - Preventive and Diagnostic	See Pediatric De	ntal Standard	See Pediatric De	ntal Standard	
, , ,	Dental Basic Services	Plan Design, Note 6 Below		Plan Design, Note 6 Below		

Notes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

Dental Restorative and Orthodontia Services

- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.

- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:
- http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf

Covered California Standard Benefit Plan Designs - FINAL

Summary of Benefits and Coverage	Individual & SHOP
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver HSA Plan
3/15/2013	
Actuarial Value - Final AV Calculator	71.5%
Overall deductible Other deductibles for specific services	\$1500 integrated Med/Rx Ded
Medical	N/A
Brand Drugs	N/A
Dental	See attachment
Out-of-pocket limit on expenses	\$6,400

Common Medical Event	Service Type	e	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an injufootnote)		20%	Х
office or clinic	Specialist visit Other practitioner office visit Preventive care/ screening/ imn	20% 20% No cost share	X	
Tests	Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)		20% 20% 20%	X X X
Drugs to treat illness or condition	Generic drugs Preferred brand drugs Non-preferred brand drugs		20% 20% 20%	X X X
Outpatient surgery	Specialty drugs Facility fee (e.g., ASC) Physician/surgeon fees Emergency room services (waiv	ved if admitted)	20% 20% 20% 20%	X X X
Need immediate attention	Emergency medical transportation Urgent care		20%	X
Hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fee		20% 20%	X
Mental health, behavioral health,	Mental/Behavioral health outpar Mental/Behavioral health inpation	20%	X	
or substance abuse needs	Substance use disorder outpati	20%	Х	
	Substance use disorder inpatier Prenatal care and preconceptio	20% No cost share	X	
Pregnancy	Delivery and all inpatient services	Hospital Professional	20% 20%	X
Help recovering	Home health care Rehabilitation services Habilitation services		20% 20% 20%	X X X
or other special health needs	Skilled nursing care Durable medical equipment		20% 20% No cost share	X X X
Child needs dental or eye care	Hospice service Eye exam (deductible waived) Glasses Dental check-up - Preventive ar Dental Basic Services Dental Restorative and Orthodo	-	0% 1 pair per year See Pediatric Der Plan Design, No	ntal Standard

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:
- http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Silver Coinsurance Plan 100%-150% FPL		Silver Coinsurance Plan 150%-200% FPL		
3/15/2013						
Actuarial Value - F	inal AV Calculator		94.89	<u>%</u>	87.8%	
Overall deductible			\$0		N/A	
	for specific services					
	Medical		\$0		\$500	
	Brand Drugs		\$0		\$50	
	Dental		See attacl	hment	See attach	nment
Out-of-pocket lim	it on expenses		\$2,25	0	\$2,25	0
Common Medical Event	Service Typ	е	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an injufootnote)	ury or illness (see	\$3		\$15	
office or clinic	Specialist visit		\$5		\$20	
	Other practitioner office visit		\$3		\$15	
	Preventive care/ screening/ imm	nunization	No cost share		No cost share	
	Laboratory Tests		\$3		\$15	
Tests	X-rays and Diagnostic Imaging		\$5		\$20	
	Imaging (CT/PET scans, MRIs)		10%		15%	X
Drugs to treat	Generic drugs		\$3		\$5	
illness or	Preferred brand drugs		\$5		\$15	X
condition	Non-preferred brand drugs		\$10		\$25	X
	Specialty drugs		10%		15%	X
Outpatient	Facility fee (e.g., ASC)		10%		15%	Х
surgery	Physician/surgeon fees		10%		15%	
	Emergency room services (wai		\$25		\$75	X
Need immediate attention	Emergency medical transportation Urgent care		\$25 \$6		\$75 \$30	×
Hospital stay	Facility fee (e.g., hospital room)		10%		15%	X
1100pital Stay	Physician/surgeon fee		10%		15%	
	Mental/Behavioral health outpa	tient services	\$3		\$15	
Mental health, behavioral health,	Mental/Behavioral health inpation		10%		15%	Х
or substance	Substance use disorder outpati	ent services	\$3		\$15	
abuse needs	Substance use disorder inpatie		10%		15%	Х
	Prenatal care and preconception		No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	10%		15%	X
	services	Professional	10%		15%	
	Home health care		10%		15%	
Holm recovering	Rehabilitation services		\$3		\$15	
Help recovering	Habilitation services		\$3		\$15	
or other special health needs Skilled nursing care			10%		15%	Х
	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived) Glasses		0%		0%	
Child needs	Dental check-up - Preventive a	nd Diagnostic	1 pair per year		1 pair per year	
dental or eye care	Dental Basic Services	ia Diagnostic			See Pediatric Der	
		ontia Services	Plan Design, No	ote 6 Below	Plan Design, No	ote 6 Below
Dental Restorative and Orthodontia Services			-		<u> </u>	

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:
- http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf

COST SHARING ENROLLEE'S	Silver Coinsurance Plan 200%-250% FPL			
3/15/2013 Actuarial Value - F	inal AV Calculator		73.7%	<u>/</u>
				0
Overall deductible			N/A	
Other deductibles	for specific services		• • • • • • • • • • • • • • • • • • • •	-
	Medical		\$1,50	
	Brand Drugs		\$250	
	Dental		See attach	
Out-of-pocket lim	it on expenses		\$5,20	U
Common Medical			Member Cost	Darkertikla
Event	Service Typ	Δ.	Share	Deductible Applies
LVent	Service Typ	C	Silare	Applies
Visit to a health care provider's	Primary care visit to treat an inj footnote)	ury or illness (see	\$40	
office or clinic	Specialist visit		\$50	
	Other practitioner office visit		\$40	
	Preventive care/ screening/ imr	munization	No cost share	
	Laboratory Tests		\$40	
Tests	X-rays and Diagnostic Imaging		\$50	
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat	Generic drugs		\$20	
illness or	Preferred brand drugs		\$30	X
condition	Non-preferred brand drugs		\$50	Х
	Specialty drugs		20%	Х
Outpatient	Facility fee (e.g., ASC)		20%	Х
surgery	Physician/surgeon fees		20%	
	Emergency room services (wai		\$250	X
Need immediate attention	Emergency medical transportation Urgent care	\$250 \$80	X	
Hospital stay	Facility fee (e.g., hospital room)	20%	X
Hospital stay	Physician/surgeon fee		20%	
	Mental/Behavioral health outpa	tient services	\$40	
Mental health, behavioral health,	Mental/Behavioral health inpati	ent services	20%	Х
or substance	Substance use disorder outpat	ient services	\$40	
abuse needs	Substance use disorder inpatie	nt services	20%	Х
	Prenatal care and preconception	on visits	No cost share	
Pregnancy	Delivery and all inpatient Hospital		20%	Х
	services	Professional	20%	
	Home health care		20%	
	Rehabilitation services		\$40	
Help recovering	Habilitation services		\$40	
or other special health needs	Skilled nursing care		20%	Х
	Durable medical equipment		20%	
	Hospice service		No cost share	
	Evo oxam (doductible waived)	Λ0/		

Notes:

Child needs

dental or eye care

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

Dental check-up - Preventive and Diagnostic

Dental Restorative and Orthodontia Services

- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.

0%

1 pair per year

See Pediatric Dental Standard

Plan Design, Note 6 Below

- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:

Eye exam (deductible waived)

Dental Basic Services

Glasses

http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Silver Copay Plan 100%-150% FPL		Silver Copay Plan 150%-200% FPL		
3/15/2013 Actuarial Value - Final AV Calculator					07.70/	
Actuarial Value - Fi	inal AV Calculator		94.9%	6	87.7%	
Overall deductible			\$0		N/A	
Other deductibles	for specific services					
	Medical		\$0		\$500	
	Brand Drugs		\$0		\$50	
	Dental		See attach	nment	See attach	nment
Out-of-pocket limit	it on expenses		\$2,25	0	\$2,25	0
Common Medical Event	Service Type	9	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an injufootnote)	ury or illness (see	\$3		\$15	
office or clinic	Specialist visit		\$5		\$20	
	Other practitioner office visit		\$3		\$15	
	Preventive care/ screening/ imm	nunization	No cost share		No cost share	
	Laboratory Tests		\$3		\$15	
Tests	X-rays and Diagnostic Imaging		\$5		\$20	
	Imaging (CT/PET scans, MRIs)		\$50		\$100	
Drugs to treat	Generic drugs		\$3		\$5	
illness or	Preferred brand drugs		\$5		\$15	X
condition	Non-preferred brand drugs		\$10		\$25	X
	Specialty drugs		10%		15%	X
Outpatient	Facility fee (e.g., ASC)		10%		15%	Х
surgery	Physician/surgeon fees	116 1 16 1	10%		15%	
	Emergency room services (waiv		\$25		\$75	X
Need immediate attention	Emergency medical transportati Urgent care	On	\$25 \$6		\$75 \$30	X
Hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fee		10%		15%	Х
	Mental/Behavioral health outpat	ient services	\$3		\$15	
Mental health, behavioral health,	Mental/Behavioral health inpatie	ent services	10%		15%	Х
or substance	Substance use disorder outpatie	ent services	\$3		\$15	
abuse needs	Substance use disorder inpatier	nt services	10%		15%	Х
	Prenatal care and preconception	n visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient services	Hospital Professional	10%		15%	Х
	Home health care		\$3		\$15	
	Rehabilitation services		\$3		\$15	
Help recovering	Habilitation services		\$3		\$15	
or other special health needs	Skilled nursing care		10%		15%	Х
	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
Child needs	Glasses		1 pair per year		1 pair per year	
dental or eye care	Dental check-up - Preventive ar Dental Basic Services Dental Restorative and Orthodo	_	See Pediatric Der Plan Design, No		See Pediatric Der Plan Design, No	
	Dental Nestolative and Ottilodo	TILLA DELVICES	ů ,		ŭ ,	

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:
- http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf

	AMOUNTS DESCRIBE THE OUT OF POCKET COSTS		Silver Copa	
ENROLLEE'S	200%-250%	% FPL		
3/15/2013			72.20	/
Actuariai value - F	inal AV Calculator		73.3%	O
Overall deductible			N/A	
Other deductibles	for specific services			
	Medical		\$1,50	
	Brand Drugs		\$250	
	Dental		See attach	
Out-of-pocket lim	it on expenses		\$5,20	0
Common Medical			Member Cost	Deductible
Event	Service Type	•	Share	Applies
Visit to a health care provider's	Primary care visit to treat an injufootnote)	ury or illness (see	\$40	
office or clinic	Specialist visit		\$50	
	Other practitioner office visit		\$40	
	Preventive care/ screening/ imm	nunization	No cost share	
	Laboratory Tests		\$40	
Tests	X-rays and Diagnostic Imaging	\$50		
	Imaging (CT/PET scans, MRIs)		\$250	
Drugs to treat	Generic drugs		\$20	
illness or	Preferred brand drugs	\$30	X	
condition	Non-preferred brand drugs		\$50	X
	Specialty drugs		20%	X
Outpatient	Facility fee (e.g., ASC)		20%	X
surgery	Physician/surgeon fees	1.6 1.66 1)	20%	
	Emergency room services (waiv		\$250	X
Need immediate attention	Emergency medical transportati Urgent care	\$250 \$80	X	
Hospital stay	Facility fee (e.g., hospital room)		20%	Х
1103pital Stay	Physician/surgeon fee			
	Mental/Behavioral health outpat	ient services	\$40	
Mental health, behavioral health,	Mental/Behavioral health inpation		20%	Х
or substance	Substance use disorder outpatie	ent services	\$40	
abuse needs	Substance use disorder inpatier	nt services	20%	Х
	Prenatal care and preconception	n visits	No cost share	
Pregnancy	Delivery and all inpatient services	Hospital Professional	20%	Х
	Home health care		\$40	
	Rehabilitation services		\$40	
Help recovering	Habilitation services		\$40	
or other special health needs	Skilled nursing care		20%	Х
	Durable medical equipment		20%	
	Hospice service		No cost share	
	Eye exam (deductible waived)		0%	
Child needs	Glasses	15:	1 pair per year	
	Dental check-up - Preventive ar			

Notes:

dental or eye care

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

Dental check-up - Preventive and Diagnostic

Dental Restorative and Orthodontia Services

Dental Basic Services

- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.

See Pediatric Dental Standard

Plan Design, Note 6 Below

- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS			Bronze Plan		Bronze HSA Plan	
3/15/2013						
Actuarial Value - F	inal AV Calculator		60.49	6	59.0%	
Overall deductible			\$5000 integrated	Med/Rx Ded	\$4500 integrated	Med/Rx Ded
Other deductibles	for specific services					
	Medical		N/A		N/A	
	Brand Drugs		N/A		N/A	
	Dental		See attacl		See attach	
Out-of-pocket lim	it on expenses		\$6,40	0	\$6,40	0
Common Medical Event	Service Type	;	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an injufootnote)		\$60	After 1st 3 non- preventive visits	40%	Х
office or clinic	Specialist visit		\$70	X	40%	X
	Other practitioner office visit		\$60	X	40%	Χ
	Preventive care/ screening/ imm	nunization	No cost share		No cost share	
	Laboratory Tests		30%	X	40%	X
Tests	X-rays and Diagnostic Imaging		30%	X	40%	X
	Imaging (CT/PET scans, MRIs)		30%	X	40%	X
Drugs to treat	Generic drugs		\$25	X	40%	X
illness or	Preferred brand drugs		\$50	X	40%	X
	Non-preferred brand drugs		\$75	X	40%	X
	Specialty drugs		30%	X	40%	X
Outpatient	Facility fee (e.g., ASC)		30%	X	40%	X
surgery	Physician/surgeon fees Emergency room services (waived if admitted)		30%	X	40%	X
	Emergency medical transportation		\$300 \$300	X	40% 40%	X
Need immediate attention	Urgent care		\$120	After 1st 3 non- preventive visits	40%	X
Hospital stay	Facility fee (e.g., hospital room)		30%	X	40%	X
	Physician/surgeon fee		30%	X	40%	X
	Mental/Behavioral health outpat	ient services	\$60	Х	40%	X
Mental health, behavioral health,	Mental/Behavioral health inpation		30%	Х	40%	Х
	Substance use disorder outpatie	ent services	\$60	Х	40%	Х
abuse needs	Substance use disorder inpatier		30%	Х	40%	Х
	Prenatal care and preconception		No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	30%	X	40%	X
	services	Professional	30%	X	40%	X
	Home health care		30%	X	40%	X
Holp receivering	Rehabilitation services Habilitation services		30%	X	40% 40%	X
Help recovering or other special health needs	Skilled nursing care		30%	X	40%	X
noutil fields	Durable medical equipment		30%	X	40%	Х
	Hospice service		No cost share	X	No cost share	X
	Eye exam (deductible waived)		0%	^	0%	
	Glasses		1 pair per year		1 pair per year	
Child needs dental or eye care	Dental check-up - Preventive ar Dental Basic Services		See Pediatric De		See Pediatric Der	
	Dental Restorative and Orthodo	ntia Services	Plan Design, Note 6 Below		Plan Design, Note 6 Below	

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Pediatric Dental Standard Plan Design may be accessed at:
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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS				Catastrophic Plan		
3/15/2013						
Actuarial Value - Final AV Calculator				60.4%		
	Overall deductible			\$6400 integrated	Med/Rx Ded	
		for specific services		φο του integration		
		Medical		N/A		
		Brand Drugs		N/A		
		Dental		See attach	nment	
	Out-of-pocket lim	it on expenses		\$6,40	0	
	Common Medical Event	Service Type	Member Cost Share	Deductible Applies		
	Visit to a health care provider's	Primary care visit to treat an injufootnote)	ury or illness (see	0%	After 1st 3 non- preventive visits	
	office or clinic	Specialist visit		0%	X	
		Other practitioner office visit		0%	X	
		Preventive care/ screening/ imm	nunization	No cost share		
	_	Laboratory Tests		0%	X	
	Tests	X-rays and Diagnostic Imaging		0%	X	
		Imaging (CT/PET scans, MRIs)		0% 0%	X	
	Drugs to treat	Generic drugs Preferred brand drugs		0%	X	
	illness or	Non-preferred brand drugs		0%	X	
	condition	Specialty drugs		0%	X	
	Outpatient	Facility fee (e.g., ASC)		0%	X	
	surgery	Physician/surgeon fees		0%	X	
	July 2017	Emergency room services (waiv	ed if admitted)	0%	X	
		Emergency medical transportati	0%	Х		
	Need immediate attention	Urgent care		0%	After 1st 3 non- preventive visits	
	Haanital atau	Facility fee (e.g., hospital room)		0%	X	
	Hospital stay	Physician/surgeon fee		0%	X	
		Mental/Behavioral health outpat	ient services	0%	Χ	
	Mental health, behavioral health,	Mental/Behavioral health inpation		0%	Х	
	or substance	Substance use disorder outpatie	ent services	0%	X	
	abuse needs	Substance use disorder inpatier	Substance use disorder inpatient services		Х	
		Prenatal care and preconception		No cost share		
	Pregnancy	Delivery and all inpatient	Hospital	0%	X	
		services	Professional	0%	X	
		Home health care Rehabilitation services		0% 0%	X	
	Help recovering	Habilitation services		0%	X	
	or other special health needs	Skilled nursing care		0%	X	
		Durable medical equipment		0%	Χ	
		Hospice service		No cost share	X	
		Eye exam (deductible waived)		0%		
	Child needs	Glasses		1 pair per year		
	dental or eye care	Dental check-up - Preventive ar	nd Diagnostic	See Pediatric De	ntal Standard	
	asinal or eye care	Dental Basic Services		Plan Design, No		
		Dontal Postarative and Orthodo	ntio Convione			

Notes:

1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

Dental Restorative and Orthodontia Services

- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including postnatal visits or outpatient Mental Health/Substance Abuse visits.

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